New Hire _____
Change in Family Status _____
Re-enrollment _____

FLEXIBLE BENEFITS ACCOUNT ENROLLMENT FORM

Please clearly print the entire form and return it to your plan administrator.

Employee's Name _____

Employee's Street Address _____

City _____ State _____ Zip Code _____

Employer's Name _____ Plan Number _____ Division Number _____

Social Security Number _____ / _____ / _____ Participant Effective Date _____

CHECK WITH YOUR EMPLOYER FOR THE EFFECTIVE DATES OF YOUR PLAN YEAR AND THE MAXIMUM ALLOWABLE FOR THE HEALTH CARE ACCOUNT AND DEPENDENT CARE ACCOUNT.

SALARY REDIRECTION FOR HEALTH CARE PREMIUMS

I understand that any premiums I am obligated to pay for health care coverage for myself and any of my dependents will be deducted from my pay on a BEFORE-TAX basis unless I otherwise direct.

ADDITIONAL SALARY REDIRECTION.

Eligible Health Care Expenses (check one)

_____ I wish to direct $ _____ Employee's annual election amount
plus _____ Employer's contribution (if applicable)
equals _____ TOTAL ANNUAL ELECTION AMOUNT
for the upcoming plan year to my Health Care account. I understand this is in addition to the amount redirected for my premiums.

_____ I do not wish to redirect any additional money for eligible health care expenses.

Eligible Dependent Care Expenses (check one)

_____ I wish to direct $ _____ Employee's annual election amount
plus _____ Employer's contribution (if applicable)
equals _____ TOTAL ANNUAL ELECTION AMOUNT
for the upcoming plan year to my Dependent Care (Daycare) Account. I understand this is in addition to the amounts which have been redirected above. I have considered the IRS tax credit available to me. I understand that if I am married and filing a separate tax return, a lower maximum applies.

_____ I do not wish to redirect any additional money for eligible dependent care expenses.

I understand that the choices I have indicated above must remain in effect for the entire plan year unless I have a change in family status. A change in family status includes the birth or adoption of a child, marriage, divorce, death, spouse losing or gaining a job, or a change in employment status from part-time to full-time or full-time to part-time. I understand that any unused balances in either account at the end of a plan year shall be forfeited.

I hereby give my employer permission to reduce my salary by the above election amounts.

Date _____ Signature _____

Flexible Benefits Account Worksheet

Your Eligible Expenses

1. Eligible health care expenses

- Deductibles, Co-payments $_____

- Out-of-pocket costs for expenses that will not be covered under any health plan or are subject to coinsurance cost sharing:

Hospital expenses _____
Physician expenses _____
Dental expenses _____
Vision and eye care, i.e., exams, glasses, contacts, radial keratotomies _____
Hearing expenses, i.e., exams, hearing aids _____
Physical examinations, i.e., annual checkups, school exams _____
Psychiatric counseling _____
Chiropractic and acupuncture treatment _____
Prescription drugs, insulin, contraceptives _____
Medical expenses for the mentally and physically handicapped _____
Drug or alcohol treatment _____
Other health care-related expenses _____

Estimated Eligible Health Care Expenses $_____

2. Eligible Dependent Care Expenses

Estimate the total amount you pay during the year for dependent care expenses. Then enter how much of that amount you want to redirect into the Dependent Care account. (Be sure the amount you redirect does not exceed your plan maximum.)
Estimated Dependent Care Expenses $_____

Plus Health Care Expenses _____

3. Add total of items 1 & 2 to determine you total annual deposit to Flexible Benefits Account (subject to plan maximums) $_____

Your payroll administrator will calculate your pre-tax deduction per paycheck for health care and dependent care expenses.